

Prioritizing Low-Cost and Effective Differentiated HIV **Testing Services:** Frequently Asked Questions

HIV testing is an essential health service and a gateway to lifesaving treatment and high-impact strategies that stop new HIV infections. However, reductions in international funding for global health—including national HIV programs—are causing disruptions in service delivery. This FAQ, offers practical guidance for countries aiming to sustain HIV testing services by implementing cost- effective and differentiated strategies

Q1. Why is it urgent to prioritize low-cost HIV testing services?

While global resources for HIV programmes are increasingly constrained, countries should prioritize approaches that maximize efficiency while safeguarding equitable access to testing, treatment, prevention and care services, particularly for vulnerable and underserved populations.

Even though HIV testing remains a critical component that of all programmes, it generally comprises less than 10% of the total HIV programme budget.

Most HIV testing costs are driven by: (1) the personnel who carry out testing services and (2) the test kits and commodities delivered. Together, these two account for over 80% of HIV testing costs.

Through targeting cost-saving efforts in these areas substantial savings can be achieved.

Q2. How should countries adopt low-cost quality assured rapid tests, starting with the first test in the national HIV testing algorithms?

The first test (assay 1, A1) in a country's national HIV testing algorithm is the biggest driver of test kit costs. Switching to a low cost, quality-assured option, such as those WHO prequalified (PQ) and listed in the WHO catalogue or available through pooled procurement mechanisms (e.g. Wambo) can yield substantial savings.

Key priorities for easing algorithm transition for more rapid savings:

- Removing a third test (often referred to as assay three, A3) will not have much impact on the cost of the testing algorithm or programme;
- Changing the first test in the algorithm (A1) while retaining second and third test (assay two and three, A2/A3) in the algorithm simplifies transition and helps preserve quality—this applies to programmes using the dual HIV/syphilis rapid test and as the first test in antenatal care;
- Compare and negotiate with landed prices in mind (inclusive of shipping and logistics) to maximize savings; Adopt country waivers to expedite access to low-cost WHO PQ HIV RDTs WHO PQ;
- Engage industry/manufacturers to cover quality assurance and training costs.

Q3.

How can countries leverage HIV self-testing (HIVST), to mitigate limited stock of the first test (A1) and limited human resources?

HIV self-testing (HIVST) continues to be a valuable approach as it is flexible and can be used by individuals independently. Also, because all those with a negative self-test result do not need further testing, follow-up and health worker time can be prioritized toward those with reactive self-test results.

WHO recommends facility-based HIVST. Any country facing staffing shortages that affect testing coverage and capacity should consider using HIVST to continue access to essential services.

Countries should prioritize the use of quality-assured HIV self-tests and the adoption of low-cost HIV self-tests to maximize limited resources. Any country facing a stock-out or limited testing capacity can consider using a self-test as the first test in the national algorithm.

Q4.

What other strategies support cost-effective HIV testing?

The following strategies support cost-effective HIV testing:

- **Task-sharing** to trained lay providers and community health workers, who can provide these services at a low cost and with little infrastructure, per WHO guidance;
- Discontinue the use of **recency assays** for routine HIV testing
 - Reserve NAT for infant diagnosis (< 18 months of age);
- Further **simplify testing** – such as HIVST for PEP and PrEP (initiation, continuation and re-initiation);
- Utilize **virtual platforms** and **private sector partnerships** (including (workplace and pharmacies).

Q5.

Which populations should countries prioritize for HIV testing when resources are limited?

Focus on
**facility-based
HIV testing**
along with
ensuring easy
access and
availability of
HIVST.

Populations to be prioritised for testing are:

- Sexually active **adults and adolescents (15+)** with HIV-related symptoms or risks, **key populations**, at any clinic/hospital;
- **Sick children** in high HIV burden ($\geq 5\%$ HIV prevalence) at any clinic/hospital
- **Pregnant women** at first antenatal visit, or catch-up testing at earliest possible time if missed;
- **HIV-exposed infants** at 6 weeks and at 6–9 months if breastfeeding;
- Individuals with **TB, HCV and STI** co-infection (tailored based on HIV/TB burden)ⁱ;
- **Sexual and injecting partners**, and biological children, of newly diagnosed PLHIV; Network-based testing for individuals from key populations or other risk networks.

Discontinuing general “window period” testing (3.g. every 3-months);

Stopping general and high frequency maternal retesting as it is not cost-effective, particularly in low HIV burden settings;

- o Reserving maternal retesting to only high HIV burden settings ($\geq 5\%$ HIV prevalence) or women is from a key population;
- o Implementing only one additional test after 1st ANC visit during the third trimester/labour and delivery (and if missed, one catch-up test can be considered);

Stopping quarterly retesting for all key populations and focusing on annual or biannual testing if resources are available;

Focusing on annual or less frequent re-testing of sexually active people in high HIV prevalence settings ($> 5\%$ HIV prevalence);

Continuing retesting as part of reengagement in care among people with HIV who have fallen out of care may continue as it is a simple and affordable welcome back service that supports the treatment programme.

Where community testing is no longer feasible, programmes should consider:

- **Network-based** HIV testing strategies focused specifically on key and high-risk populations outside of healthcare facilities.

Implement strategies tailored to local needs and priorities, such as:

- **Collaborating with community stakeholders** to plan periodic (1-3 years) outreach testing activities based on latest epidemiology;
- **Offering workplace testing** for men in high-risk industries through financing and partnerships with the private sector;
- **Promoting virtual service delivery** and expand HIVST access through pharmacies and user-paid delivery options.

KEY IMPLEMENTATION CONSIDERATIONS

- It should be noted that decisions regarding reduced retesting frequency should be guided by local epidemiology, community consultation, and ongoing monitoring of HIV incidence trends to ensure that reduced testing does not lead to delayed diagnoses or increased transmission.
- Where user-paid options are introduced, programmes should ensure that free or subsidized services remain available for low-income populations, key populations, adolescents, and other groups facing financial or structural barriers to healthcare access.
- Countries should meaningfully engage networks of people living with HIV and advocates, at the same time, Community-led monitoring mechanisms should be utilized to identify unintended consequences and ensure accountability.

Q8.

Should countries continue to test for Pre-Exposure Prophylaxis (PrEP) and Post Exposure Prophylaxis (PEP)?

Yes. HIV testing remains essential, but should be simplified:

For PEP, oral PrEP and the dapivirine vaginal ring: Use RDTs and/or HIVST – including for initiation, continuation, and re-initiation;

For long-acting injectable (LA) PrEP: Use RDTs for initiation and monitoring;

Testing time points should also be aligned to the most feasible and affordable option according to refill or injection visit schedule, as well as the PrEP service delivery approach used, e.g. multi-month dispensing, TelePrEP.

Q9.

Should blood donations be screened for HIV?

Yes, WHO recommends systematic screening of all blood donations for HIV, as well as hepatitis B, hepatitis C, and syphilis among others, before use in clinical care. This is generally a high impact investment and should be maintained.

MONITORING THE IMPACT OF SERVICE CHANGES

Countries should establish mechanisms for routine monitoring of the impact of HIV testing service changes, including:

KEY INDICATORS INCLUDE:

✓ HIV testing uptake

✓ Positivity yield

✓ Linkage to treatment

✓ Client satisfaction

✓ Service accessibility

✓ Impact on key populations

✓ Stock-outs and service disruptions

Community-led monitoring systems should be integrated into these efforts to ensure that programme adjustments remain responsive to community needs.

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